

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN4704	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  12/03/2013	
NAME OF PROVIDER OR SUPPLIER  FORT SANDERS TCU		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 CLINCH AVE KNOXVILLE, TN 37916		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies  During the Life Safety portion of the annual Licensure survey conducted on December 3, 2013, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6099

BEXG21

If continuation sheet 1 of 1